

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

09318

1310

## 1. PLACE OF DEATH:

County CecilCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Elkton HospitalHow long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County KentCity or town Bellevue Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George A. Briscoe

## 3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Katie Briscoe7. Birth date of deceased (mo., day, yr.) Oct 11, 1883 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 64 Months mar Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace md  
(Town, county, and state)10. Usual occupation Laundry

11. Industry or business \_\_\_\_\_

12. Name Briscoe13. Birthplace md14. Maiden name Emma Briscoe15. Birthplace md16. Informant Viola HackettAddress 2010 Delancey St Phila17. Burial Date thereof Sept 27 '48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Olive HillLocation Olive Hill md18. Funeral director Arthur O. PaulkAddress 827 Pine St, Phila. Md19. Sept 26 19 48 TH. Frazer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Sept 19 48 at 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Sept 19 48 to 23 Sept 19 48and that I last saw him alive on 23 Sept 19 48

Immediate cause of death

Bronchopneumonia

DURATION

2 daysDue to Arteriosclerotic Heart DiseaseBenign nephrosclerosis10 years10 years

Due to \_\_\_\_\_

Other conditions Benign prostatic hypertrophy10 years

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Klaus H. Huchner M.D.

M. D. or other

Address North East Md Date signed 24 Sept 48

MARGIN RESERVED FOR BINDING

VS A15

9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 yrs. 5 mos. 26 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Va. County Hancock  
 City or town Weirton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1070 Third Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW I

## 3. (a) FULL NAME

BULAICH, George

## 3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anna Sompin  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 24, 1888

8. AGE: Years 60 Months 5 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Tol. Servia  
 (Town, county, and state)

10. Usual occupation Mill worker

11. Industry or business \_\_\_\_\_

12. Name Unknown - deceased  
 13. Birthplace Servia

14. Maiden name Sara - deceased  
 15. Birthplace Servia

16. Informant Hospital records  
 Address VAH, Perry Point, Md.

17. Removal Date thereof 9-17-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery  
 Location Baltimore, Maryland

18. Funeral director PENNINGTON & SON  
 Address Havre de Grace, Md.

19. Sept 17, 1948 James E. Daugherty  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1932 to Sept. 15, 1948

and that I last saw him alive on September 15, 1948

Immediate cause of death Chronic myocarditis and myocardial degeneration DURATION Unknown

Due to Coronary arteriosclerosis Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions General Paresis

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. Trollinger M. D. or other \_\_\_\_\_

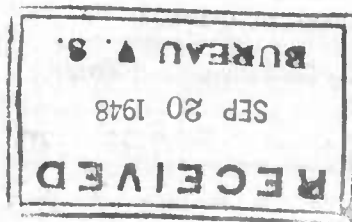
A. E. TROLLINGER, M.D., Chief, Professional Svcs

Address VAH, Perry Point, Md. Date signed 9-17-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09320

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County  Cecil   
 City or town  Cecilton and   
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  1 yr & 6 mo   
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

 Mary E. Davis 

4. Sex  female  5. Color or race  white  6. (a) Single, married, widowed, or divorced  widowed   
 6. (b) Name of husband or wife  Conlious W. Davis   
 7. Birth date of  Oct 29<sup>th</sup>, 1883  8. (c) If alive, give age   years  
 8. AGE: Years  64  Months   Days   If less than one day   hrs.   min.

9. Birthplace  Ind.  (Town, county, and state)  
 10. Usual occupation  Housewife   
 11. Industry or business  farming   
 12. Name  James E. Pierce   
 13. Birthplace  Ind.   
 14. Maiden name  Mary E. Davis   
 15. Birthplace  Phila. Pa.   
 16. Informant  Mrs. Maude Plaine   
 Address  Kennedyville and   
 Forest   
 17. (Burial, cremation, or removal. Which?) Date thereof  9/13/48  (month) (day) (year)  
 Cemetery or crematory  Forest Cemetery Middletown Md   
 Location  J. G. Daniels   
 18. Funeral director  J. G. Daniels   
 Address  Middletown Md   
 19.  Sept 11, 1948   Margaret A. Cheaney   
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State  Md  County  Cecil   
 City or town  Cecilton and   
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.    
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH  Sept- 11  19  48  at  5<sup>30</sup>  A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  Sept 10  19  48 , to  Sept 11  19  48 .  
 and that I last saw her alive on  Sept 10  19  48 .  
 Immediate cause of death  chronic cardio-renal disease   
 DURATION    
 Due to  Arterio sclerosis   
 Due to    
 Other conditions  marked Anemia   
 (Include pregnancy within 3 months of death)  
 Major findings of operations   Date of op.    
 Autopsy results    
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  none  Date of    
 Where did injury occur?  home  (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)    
 Means of injury   Injured at work?    
 23. SIGNATURE  W. H. Hamilton  M. D. or other    
 Address  Millington Md  Date signed  Sept 11/48

RECEIVED  
SEP 14 1948  
BUREAU V. B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09321

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Where)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 6. 8.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 3, 1948, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

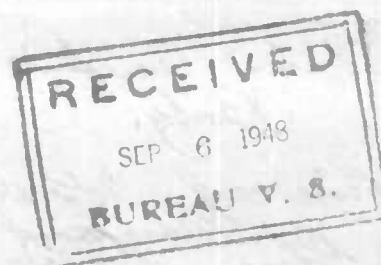
Address

Medical Examiner

for Cecil County

M. D. or other

Date signed





MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

09322

830

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil  
City or town Perry Point, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 days  
Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Harford  
City or town Havre de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 358 Bourbon Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW-I

3. (a) FULL NAME

HYLAND, Charles R.

3. (b) Social Security Number

Unknown

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1898 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 50 Months 7 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital Records

Address VAH, Perry Point, Md.

17. Burial Date thereof 9-19-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Angel Hill Cemetery

Location Havre de Grace, Md.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. Sept. 19, 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1948 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 11, 1948 to Sept. 16, 1948 and that I last saw him alive on September 16, 1948

Immediate cause of death Pneumonia, bronchial, bilateral DURATION 4-5 days

Due to Status epilepticus

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Cerebral hemorrhage  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. Trollingier

A. E. TROLLINGER, M.D., Chief, Professional Svcs.

Address VAH, Perry Point, Md. Date signed 9-17-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09323

Reg. Dist. No. 91

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Mrs. Lapush

7. Birth date of deceased (mo., day, yr.)

December 23 1889

6. (c) If alive, give age..... years

8. AGE:

Years 58

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Rustonia, Va., and state

10. Usual occupation

Baker

11. Industry or business

Baker

FATHER

12. Name

Pete Lapush

13. Birthplace

Rustonia

MOTHER

14. Maiden name

No information

15. Birthplace

16. Informant

Mrs. Vera Lapush

Address

Burrill St. 30 1948

17. (Burial, cremation, or removal, Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

St. Paul's

Location

St. Paul's

18. Funeral director

Elkton, Md.

Address

Sept 29 1948

19. (Date rec'd by registrar)

1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 28 1948 at 5:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1947 to Sept 28 1948

and that I last saw him alive on September 27 1948

Immediate cause of death

Cancer of the stomach

DURATION

13 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

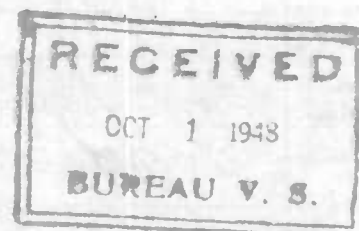
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. It is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

09324

157a

## 1. PLACE OF DEATH:

County CecilCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hrs.

Hospital, institution, or street address where death occurred:

Union HospitalHow long in hospital or institution? 2 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County CecilCity or town rural Rising Sun  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

GEORGE SAMUEL Baby MacCauley

## 3. (b) Social Security Number \_\_\_\_\_

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1948

## 8. AGE:

Years

Months

Days

If less than one day

2 hrs. \_\_\_\_\_ min.

## 9. Birthplace

Elkton, Cecil Co.  
(Town, county, and state)

## 10. Usual occupation \_\_\_\_\_

## 11. Industry or business \_\_\_\_\_

## MOTHER FATHER

## 12. Name

Everett MacCauley

## 13. Birthplace

West Chester Pa.

## 14. Maiden name

Marie Kelley

## 15. Birthplace

Roanoke Va.16. Informant Everett MacCauleyAddress Rising Sun, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 18, 1948  
(month) (day) (year)Cemetery or crematory West Nottinghamnear Coloma, Md.

## Location

18. Funeral director A. E. TysonAddress Rising Sun, Md.19. Sept. 17, 48

(Date rec'd by registrar)

IR Frazier

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 19 48 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18. \_\_\_\_\_ to 19. \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on 19. \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Due to Prematuresonnch gestationDue to Hydrocephalus

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Alfred W. Frazier

M. D. or other \_\_\_\_\_

Address Rising Sun, Md. Date signed 9-17-48

RECEIVED  
SEP 18 1948  
BUREAU A. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 months 16 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Maryland  
 How long in hospital or institution? 6 months 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 919 Cathedral Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-I

## 3. (a) FULL NAME

MC KEWEN, William A.

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) October 28, 1896 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 51 Months 10 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Clerk

## 11. Industry or business

12. Name William A. McKewen13. Birthplace Baltimore, Maryland14. Maiden name Anna Carroll Sherlock15. Birthplace Baltimore, Maryland16. Informant Hospital RecordsAddress VAH, Perry Point, Maryland

17. removal Date thereof 9-4-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory NationalLocation Baltimore, Maryland18. Funeral director PENNINGTON & SONAddress Havre De Grace, Maryland

19. Sept 4 19 48 James E. Daugherty  
 (Date freed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1948 at 9:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18, 1948 to September 3, 1948

and that I last saw him alive on September 3, 1948

Immediate cause of death PNEUMONIA BRONCHIAL DURATION 4 days

Due to CARCINOMA OF THE PANCREAS UnknownDue to ARTERIOSCLEROSIS GENERALIZED Unknown

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. Trollinger M. D. Physician

Chief Professional Services,  
 Address VAH, Perry Point, Md. Date signed 9-4-48



RECEIVED

SEP 7 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09326

Reg. Dist. No. 96

### 1. PLACE OF DEATH:

County..... Cecil  
City or town..... Perry Point, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 Years 8 Months 15 Days  
Hospital, institution, or street address where death occurred:  
V.A. Hospital, Perry Point, Maryland  
How long in hospital or institution? 25 Years 8 Months 15 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pennsylvania County..... Franklin  
City or town..... Waynesboro  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2. (a) If veteran, name war..... World War 1.

### 3. (a) FULL NAME

Edward Middower

### 3. (b) Social Security Number

4. Sex..... Male  
5. Color or race..... White  
6. (a) Single, married, widowed, or divorced..... Single  
6. (b) Name of husband or wife.....  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... November 29, 1890  
8. AGE: Year..... 57 Month..... 9 Day..... 20 If less than one day..... hrs. .... min.

9. Birthplace..... Franklin County, Pennsylvania  
(Town, county, and state)  
10. Usual occupation..... Horticulturist  
11. Industry or business.....  
12. Name..... Unknown  
13. Birthplace.....  
14. Maiden name..... Unknown  
15. Birthplace.....

16. Informant..... Hospital Records  
Address..... VAH, Perry Point, Md.  
17. Burial..... Date thereof..... Sept. 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Green Hill Cemetery  
Location..... Waynesboro, Pennsylvania.  
18. Funeral director..... WALTER Y. GROVE, FUNERAL DIRECTOR,  
Address..... Waynesboro, Pennsylvania.  
19. Date rec'd by registrar..... Sept. 19, 48 Registrar.....

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 18, 1948 at 3:50 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/23/23 to 9/18/48 and that I last saw him alive on September 18, 1948  
Immediate cause of death..... Tuberculosis, Pulmonary, Bilateral, Extensive.

DURATION  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results..... Same as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?  
23. SIGNATURE..... A. E. TROLLINGER, M.D., Chief, Professional Services, Perry Point, Md.  
Date signed..... 9/18/48

MARGIN RESERVED FOR BINDING

9-45-15W

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

09327

87c

## 1. PLACE OF DEATH:

County CecilCity or town Cecil  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CecilCity or town Cecil  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harriett Ida Padley

## 3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife George Padley

8.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 18648. AGE: Year 84 Months \_\_\_\_\_ Day \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name William Herman13. Birthplace md14. Maiden name Mary Jane15. Birthplace md16. Informant Mrs. Herman MitchellAddress Cecil md17. Burial Date thereof Sept 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CecilLocation Cecil md18. Funeral director Edward FellowsAddress Cecil md19. Sept 11, 1948 Mrs. Harriet W. Cheyney  
(Date rec'd by registrar) (Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 19 48, at 5:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 19 40 to Sept 10 19 48and that I last saw him alive on Sept 9 19 48Immediate cause of death Parkinson's disease  
(Cauly's agitations)DURATION 8 1/2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Allan R. Cruckley M.D.Address Middleton, Md Date signed Sept 10, 48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

09328

## 1. PLACE OF DEATH:

County..... Cecil

City or town..... Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Cecil

City or town..... Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Beatrice Irena Pugh

## 3. (b) Social Security Number

4. Sex..... Female

5. Color or race..... white

6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... E. Ray Pugh

6. (c) If alive, give age..... 63 years

7. Birth date of deceased (mo., day, yr.)..... Oct. 6, 1883

8. AGE: Years..... 64 Months..... 11 Days..... 20 It less than one day..... hrs. .... min.

9. Birthplace..... Grant, Va.

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Alexander Young

13. Birthplace..... Edgewater, Va.

14. Maiden name..... Mary Pierce

15. Birthplace..... Va.

16. Informant..... E. Ray Pugh

Address..... Elkton, Md. R.H.D. 45-

17. Burial..... Date thereof..... Sept. 29, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory..... Cherry Hill

Location..... Outside of Elkton

18. Funeral director..... J. E. Tyson

Address..... Rising Sun, Md.

19. Date of death by registrar..... Sep 27, 48 Registrar..... L. M. Worthington

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 26, 1948, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1948, to Sept 26, 1948, and that I last saw him alive on Sept. 28, 1948.

Immediate cause of death..... Carcinoma of Bile Duct and Gall Bladder

## DURATION

Due to.....

Due to.....

Other conditions..... None

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma as above Metastasis to liver Date of op. July 30, 1948

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... One and H. Sprecher, no.

Address..... Elkton, Md. Date signed..... Sept 26, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

RECEIVED

SEP 29 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 minutes  
 Hospital, institution, or street address where death occurred: Union Hospital  
 How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residences of mother)

State N.Y. County  
 City or town Brooklyn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1144 - 65 St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

John Lawrence Ranieri (Ranieri)

## 3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 25 1919

8. AGE: 29 Years 9 Months 3 Days If less than one day hrs min

9. Birthplace New York, N.Y.  
 (Town, county, and state)  
 10. Usual occupation Labor

## 11. Industry or business

12. Name James Ranieri  
 13. Birthplace Italy  
 14. Maiden name Theresa Colosimo  
 15. Birthplace New York

16. Informant Dr. H. G. Davis  
 Address Chesapeake City, Md.

17. Burial Date thereof October 1 / 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bethel  
 Location New Chesapeake City, Md

18. Funeral director H. J. Papp  
 Address Elkton, Md

19. Sept 30 19 48 F. J. Fraga  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 19 48 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death  
 6. (a) Immediate cause of death  
 6. (b) Compensatory  
 Due to Rheumatic fever  
 Due to

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE R. D. Dockson  
 Address Pikesville, Md. Medical Examiner for Cecil County  
 M. D. or other 9/25-48  
 Date signed

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09330

Reg. Dist. No. 94

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

John Rekrut

## 3. (b) Social Security Number

226-03-9081

4. Sex.....  
 5. Color or race.....  
 6. (a) Single, married, widowed, or divorced.....  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal. Which?)..... Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. 9/13..... 48..... Sarah S. Rothman.....

(Date rec'd by registrar)..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 11..... 1948..... at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

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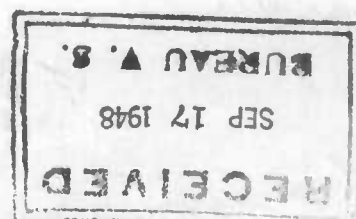
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09231

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years 3 mos. 19 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? 20 years 3 mos. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Pennsylvania County Lehigh  
 City or town Slatington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 260 S. 2nd Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

SHOENBERGER, Wesley W.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 B. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) October 20, 1890  
 8. AGE: Years 57 Months 10 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Slatington, Penna.  
 (Town, county, and state)  
 10. Usual occupation Clerk  
 11. Industry or business \_\_\_\_\_  
 MOTHER FATHER  
 12. Name M. Edward Shoenberger  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace II

16. Informant Hospital Records  
 Address VA Hospital, Perry Point, Md.  
 17. Burial Burial Date thereof 9-7-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Union Cemetery  
 Location Slatington, Lehigh County, Pa.  
 18. Funeral director Lee A. Patterson & Son  
 Address Perryville, Pa.  
 19. Sept 4 19 48 Irma E. Dougherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1948 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1928 to September 3, 1948  
 and that I last saw him alive on September 3, 1948

Immediate cause of death CORONARY OCCLUSION DURATION 5 min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Dementia Praecox, Hebephrenic type 20 yrs  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. Trollingier M.D., Chief, M. D. or other  
Professional Services  
 Address VA Hospital, Perry Point, Md. Date signed 9-4-48

RECEIVED

SEP 7 1948

BUREAU V. S.

RECEIVED

SEP 7 1948

BUREAU V. S.



....Date signed...1/20/70

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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SEP 27 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09333

95

## 1. PLACE OF DEATH:

County CecilCity or town Port Deposit Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 39 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CecilCity or town Port Deposit  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lewis Ervin Smith

## 3. (b) Social Security Number

198-10-8710

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 19098. AGE: Years 39 Months 7 Days 3 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Port Deposit, Md. R.D. 1  
(Town, county, and state)10. Usual occupation Laborer

## 11. Industry or business

12. Name Charles Smith13. Birthplace Port Deposit, Md. R.D.14. Maiden name Alice Pearson15. Birthplace Harford Co. Md.16. Informant Mines SmithAddress Port Deposit17. Burial Date thereof Sept 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory BethelLocation Near Port Deposit18. Funeral director A. S. TysonAddress Rising Sun, Md.19. Sept 8, 48 L. M. Worthington  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948 at 1300 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Due to Internal hemorrhage & stroke

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results Internal hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 9-7-48Where did injury occur Canal Port Deposit, Md  
(City or town) (State)Injured at home, farm, industry, public place (where) Public RoadMeans of injury Shot Gun - mome Injured at work? \_\_\_\_\_23. SIGNATURE R. L. Dockson M. D. or other \_\_\_\_\_Address Rising Sun, Md. Date signed 9-8-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 10 1948

BUREAU V. S.

09334

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... **CECIL**  
 City or town..... **PERRY POINT, MARYLAND**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **29 days**  
 Hospital, institution, or street address where death occurred:  
**VAH, Perry Point, Maryland**  
 How long in hospital or institution?..... **Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... **Maryland** County..... **Cecil**  
 City or town..... **Elkton**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **R. F. D. #5**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **WW-I**

## 3. (a) FULL NAME

**ALONZO LEACH SPEACE**

## 3. (b) Social Security Number

**705-09-1671**

4. Sex..... **Male**  
 5. Color or race..... **White**  
 6. (a) Single, married, widowed, or divorced..... **Married**  
 6. (b) Name of husband or wife..... **Charlotte K. Speace**  
 7. Birth date of deceased (mo., day, yr.)..... **February 4, 1897**  
 6. (c) If alive, give age..... **38** years  
 8. AGE: Years..... **51** Months..... **6** Days..... **28**  
 If less than one day..... hrs. .... min.

9. Birthplace..... **New Jersey**  
 (Town, county, and state)  
 10. Usual occupation..... **Telegraph Operator**  
 11. Industry or business.....  
 12. Name..... **Unknown**  
 13. Birthplace.....  
 14. Maiden name..... **Unknown**  
 15. Birthplace.....

16. Informant..... **Hospital Records**  
 Address..... **VA Hospital, Perry Point, Md.**  
 17. Removal..... **9/2/48**  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)  
 Cemetery or crematory..... **West Nottingham Cemetery**  
 Location..... **West Nottingham, Maryland**  
 18. Funeral director..... **J. C. Carl, Tyson**  
 Address..... **Rising Sun, Maryland**

19. **Sept. 2** 19 **48** **Irvin E. Daugherty**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **September 2nd** 19 **48** at **10:25 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**August 4th** 19 **48** to **Sept. 2nd** 19 **48**  
 and that I last saw him alive on **September 2nd** 19 **48**

Immediate cause of death..... **Pneumonia, lobar, right**  
 DURATION..... **2 to 3 days**

Due to..... **Infarction myocardial left ventricle**  
 DURATION..... **2 to 3 wks**

Due to..... **Coronary sclerosis**  
 DURATION..... **Unkn.**

Other conditions..... **Arteriosclerosis, Generalized**  
 (Include pregnancy within 3 months of death)  
 DURATION..... **Unkn.**

Major findings of operations.....  
 Date of op. ....

Autopsy results..... **Confirms above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work? .....

23. SIGNATURE..... **W. OPPEL, M.D., Act. Chf., Prof. Services**  
**VAH, Perry Point, Md.** M. D. of ..... **9/2/48**  
 Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09335

158

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Ellicott, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Cecil  
 City or town... Ellicott  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 129 Millers Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alfred Lewis Stevenson

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) Sept 8, 1948

8. AGE: Years Months Days If less than one day  
 2 hrs. min.

9. Birthplace... Ellicott, Md.  
 (Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name... Lewis, John  
 13. Birthplace... Virginia  
 14. Maiden name... Mary Stevenson  
 15. Birthplace... Ellicott, Md.

16. Interment... Miss Mary Stevenson  
 Address... Ellicott, Md.

17. (Burial, cremation, or removal. Which?) Date thereof... Sept 10, 48  
 (month) (day) (year)

Cemetery or crematory... Ellicott Colored Cemetery  
 Location... Ellicott, Md.

18. Funeral director... New Peoples  
 Address... Ellicott, Md.

19. Sept 10, 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1948, at 2:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 8, 1948, to Sept 8, 1948  
 and that I last saw him alive on Sept 8, 1948

Immediate cause of death

Respiratory Failure  
 DURATION 30 min

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. Johnson M.D. or other

Address... Ellicott, Md. Date signed 9/9/48

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

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Signature of Burial

Signature of Interment

RECEIVED

SEP 13 1948.

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 93d

### 1. PLACE OF DEATH:

County Cecil  
City or town North East Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Cecil  
City or town North East Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

William Henry Stewart

### 3. (b) Social Security Number

713 Non 8557

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Mary C Stewart

7. Birth date of deceased (mo., day, yr.) Nov 11 1877

8. AGE: Years Months Days If less than one day  
70 11 4 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wilmington, New Castle Co. Del  
(Town, county, and state)

10. Usual occupation Am. Railway Express Employee

### 11. Industry or business

12. Name John R Stewart

13. Birthplace Delaware

14. Maiden name no record

15. Birthplace \_\_\_\_\_

16. Informant Mrs William H Stewart

Address \_\_\_\_\_

17. Burial Date thereof Oct 19 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory Union

Location Elbtown Rd md

18. Funeral director Joseph R. Glaus

Address North East, md

19. Oct 18 48 Wilmington  
Date signed by Registrar (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1948 at 10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 48 to Sept 15 48

and that I last saw him alive on June 15 48

Immediate cause of death Cerebral Occlusion

### DURATION

2 days

Due to Hypertensive Heart disease 5 years

Due to Congestive heart failure 6 months

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE F.B. Robinson M.D.

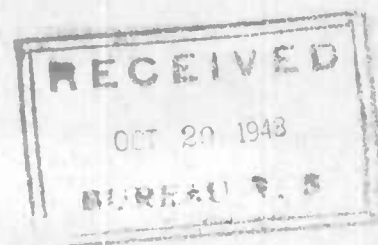
Address Oxford, Penn Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09336

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County... Cecil

City or town... Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Union Hospital - Elkton, Md.

How long in hospital or institution? 29 days

## 3. (a) FULL NAME

Anna May Vaughan

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William Vaughan

7. Birth date of deceased (mo., day, yr.)

May 31 - 1881

8. AGE:

67

Year

Month

Day

If less than one day

hr.

min.

9. Birthplace

Colesburg, Pa., Cecil, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

House

12. Name

W. Cleve A. Queck

13. Birthplace

Philadelphia, Pa.

14. Maiden name

Susan Sot's lace

15. Birthplace

Penn.

16. Informant

Hosp. record

Address

William Vaughan (216 Bow St. Elkton)

17. Burial

(Burial, cremation, or removal. Which?)

Date thereon

Sept 25/48

(month) (day) (year)

Cemetery or crematory

Bethel

Location

New Chesapeake City, Md

19. Funeral director

H. W. Pappas

Address

Elkton, Md

19. Date

Sept 25 19 48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Cecil

City or town

Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

216 Bow

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 22 19 48 at 5:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 19 46 to Sept 22 19 48

and that I last saw him alive on

Sept 21 19 48

Immediate cause of death

Bronchio-pneumonia

DURATION

9-18

Due to

Fractured femur, left

Due to

Aug. 21

Other conditions

Cardio-vascular-renal

disease - and Diabetes mellitus.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

Elkton

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Nature of injury

Injured at work?

23. SIGNATURE

Dr. H. W. Pappas

Elkton, Md

Date signed

Sept 22-48

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SEP 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

09337

46a

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Perry Point, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Unknown  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... WW-I

## 3. (a) FULL NAME

WANNALL, Bernard L.

## 3. (b) Social Security Number

Unknown

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Isabella B. Wannall  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... December 9, 1896  
 8. AGE: Years..... 51 Months..... 9 Days..... 14 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D.C.  
 (Town, county, and state)

10. Usual occupation..... Gardener

## 11. Industry or business

12. Name..... Unknown  
 13. Birthplace..... Unknown  
 14. Maiden name..... Unknown  
 15. Birthplace..... Unknown

16. Informant..... Hospital Records  
 Address..... VAH, Perry Point, Md.

17. Removal..... Removal Date thereof..... 9-24-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National Cemetery  
 Location..... Fort Myer, Virginia

18. Funeral director..... PENNINGTON & SON  
 Address..... Hayre de Grace, Md.

19. Sept. 24 19 48 James E. Daugherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 23, 1948 at 3:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 25, 1948 to September 23, 1948  
 and that I last saw him alive on September 23, 1948

Immediate cause of death.....  
1. Carcinoma of esophagus  
2. Terminal pneumonia

Due to.....  
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE.....  
A.E. TROLLINGER, M.D., Chf., Professional Svcs.  
 Address..... VAH, Perry Point, Md. Date signed..... 9-24-48

DURATION  
Unknown  
Unknown

**RECEIVED**

SEP 28 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09338

48a

92

## 1. PLACE OF DEATH:

County.....*Cecil*  
 City or town.....*Providence*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*lifetime*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....*md* County.....*Cecil*  
 City or town.....*Elkton Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Ella Mae Willey*

## 3. (b) Social Security Number

*none*

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

*Female White Married*

6.(b) Name of husband or wife

*Roland L Willey*

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age

*Jan 8, 1891*

8. AGE: Years Months Days If less than one day  
*57 7 23* hrs. min.

9. Birthplace

*Providence Cecil & Md*

10. Usual occupation

*Housewife*

11. Industry or business

12. Name

*Abraham H. Spratt*

13. Birthplace

*md*

14. Maiden name

*Annie Keithley*

15. Birthplace

*md*

16. Informant

*Roland L Willey*

Address

*Elkton R D 50 md*

17. (Burial, cremation, or removal. Which?) Date thereof

*Burial* *Sept 14 1948*  
 (month) (day) (year)

Cemetery or crematory

*Methodist*

Location

*Cherry Hill md*

18. Funeral director

*Joseph W. Grant*

Address

*North East md*

19. (Date rec'd by registrar) 19

*Sept 13 1948*  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*9/11/48*.....19*48*, at *4:43* PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*June*.....19*45* to *9/11*.....19*48*

and that I last saw him alive on *9/11*.....19*48*

Immediate cause of death.....*Bacterial Pneumonia*

Due to.....*Cardiomyopathy*

Due to.....*Cardiomyopathy*

Other conditions.....

Major findings of operations.....*Cardiomyopathy*

Date of op.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Arthur L. Menden*

Address.....*2000 Newell St* Date signed.....*9/11/48*

Address..... Date signed.....

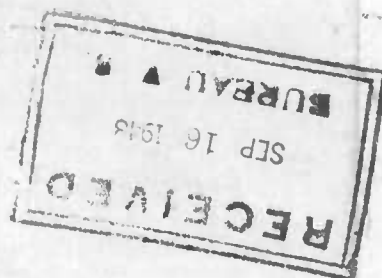
MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs. 9 mos. 23 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? Continuously since 1941

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Missouri County Crawford  
 City or town Steelville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I

## 3.(a) FULL NAME

WIMMER, (Mrs.) Lulu B.

## 3.(b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Divorced  
 6.(b) Name of husband Unknown  
 7. Birth date of deceased (mo., day, yr.) June 26, 1872  
 8. AGE: Years 76 Months 3 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 6.(c) If alive, give age \_\_\_\_\_ years

9. Birthplace Fort Scott, Kansas  
 (Town, county, and state)  
 10. Usual occupation Nurse  
 11. Industry or business \_\_\_\_\_

12. Name Ormal C. Bender - deceased  
 13. Birthplace Tennessee  
 14. Maiden name Edna G. Lowe - deceased  
 15. Birthplace Richmond, Indiana

16. Informant Hospital Records  
 Address VA Hospital, Perry Point, Md.

17. Burial Date thereof Oct. 1, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
 Location Fort Myer, Virginia

18. Funeral director PENNINGTON & SON  
 Address Havre de Grace, Maryland

19. Sept. 29 19 48 Drew S. Langlois  
 (Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 19 48 at 5:27 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4, 19 43 to Sept. 27, 19 48 and that I last saw him or alive on September 27, 19 48.

Immediate cause of death Chronic myocarditis and myocardial degeneration  
 DURATION Unknown

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. TROLLINGER M.D., Chief Professional Services  
 Address VAH, Perry Point, Md.

